DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/01/12

PRINTED: 10/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445205	A. BUILDING _____ B. WING _____	10/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF CHATTANOOGA	8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended: October 26, 2012	F 000	~~Preparation and/or execution of this plan~~ of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.	F 156	F-156 1. Residents #95, #46, and #11suffered no harm. Resident # 95 was sent a Medicare denial letter on 10-17-12. Resident #46 was sent a Medicare denial letter on 10-18-12. Resident #11 was provided with a written copy of Resident's Rights on 10-25-12. 2. The facility's Business Office Manager reviewed all current facility residents to ensure that appropriate liability and appeal notices in the form of a Medicare denial letter have been sent during the last 30 days, as applicable. Any current resident identified as not having received a Medicare denial letter, as applicable, was sent the appropriate liability and appeal notice. The facility's Admission Coordinator reviewed all current facility residents to ensure that they received a written copy of Resident's Rights upon admission to the facility. Any current residents identified as not having received a written copy of Resident's Rights upon	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 10-31-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents	F 156	admission was provided with a copy. The Regional Business Office Manager re-educated the facility's Business Office Manager on the facility's Policy and Procedure for Medicare denial letters to ensure appropriate notification to residents of their liability and appeal. The Regional Director of Admissions re-educated the facility's Admissions Coordinator and Admissions Department on the facility's Policy and Procedure of Resident Notification and Consent to ensure residents are aware of their Resident's Rights. 3. The facility's Administrator/Director of Clinical Services/Business Office Manager will conduct Quality Improvement (QI) monitoring of Medicare denial letters to ensure appropriate notification and appeal for residents. The facility's Administrator/Director of Clinical Services/Business Office Manager will also conduct QI monitoring of Resident's Rights to ensure appropriate notification upon admission to the facility. QI monitoring will be conducted 3 x weekly for 12 weeks then 1 x monthly for 9 months using a sample size of 6. 4. The facility's Administrator/Director of Clinical Services will report	

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F 156	Continued From page 2 concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation, interview, and medical record review, the facility failed to provide two residents (#46, #95) of three residents reviewed with an appropriate liability and appeal notice, and failed to provide resident rights in writing for one resident (#11) of forty-three sampled residents. The findings included: Review of facility documentation for two residents #46, and #95, revealed no denial letter and the beneficiary had not been advised of his/her rights to have a claim submitted to Medicare or advise the standard claim appeal rights if the claim was denied by Medicare.	F 156	results of QI monitoring to the Quality Assurance/Performance Improvement (QA/PI) Committee monthly x 12 months for continued compliance and/or revision. Substantial Compliance 12-1-12	

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F 156	Continued From page 3 Interview with the Office Manager on October 16, 2012, at 4:28 p.m., in the front office, confirmed the facility failed to provide the residents a liability and/or appeal notice. Resident #11 was admitted to the facility on May 21, 2012, with diagnoses including Personality Disorder, Depressive Disorder, Hypertension, Atrial Fibrillation, and Congestive Heart Failure. Medical record review of the quarterly Minimum Data Set dated August 30, 2012, revealed the resident had no cognitive impairment. Interview with the resident on October 17, 2012, at 9:00 a.m., in the resident's room, revealed the resident stated had never recieved a copy of the resident's rights and wanted a copy. Review of admission documentation and interview with the Social Worker on October 17, 2012, at 10:40 a.m., in the conference room, confirmed the resident had signed and initialed all the admission paperwork except the section indicating, "I hereby acknowledge that I have received copies of the following information and that it has been clearly explained to me by the facility staff. Patient Rights..." Further interview confirmed the admission documentation did not indicate the resident had received a written copy of the Patient Rights.	F 156		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to	F 221	F-221 1. Resident #1 suffered no harm. Resident #1's ½ side rails were removed from the center of the bed and ¼ padded side rails were placed at the head of the bed to aid the resident with turning and	

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F 221	Continued From page 4 treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete a pre-restraining assessment and obtain an order for a restraint for one resident (#1) of three residents reviewed of forty-three sampled residents. The findings included: Resident #1 was admitted to the facility on July 23, 2002, and readmitted July 22, 2011, with diagnoses including Dementia, Anxiety, Left Hemiparesis, and Anemia. Medical record review of the quarterly Minimum Data Set (MDS) dated August 20, 2012, revealed the resident was cognitively intact for daily decision making, was totally dependent on staff for bed mobility, transfers, and no restraint in use. Medical record review of the Care Plan dated March 6, 2012, revealed "...1/2 rails for increase mobility and safe turning...velcro self release belt with alarm..." Medical record review revealed no pre-restraining assessment had been completed. Medical record review of the Quarterly Collection Data dated August 11, 2012, revealed no restraints, and the side rail assessment had not been completed.	F 221	repositioning while in the bed per the physician's order. Resident #1's Velcro self-releasing alarming seat belt was discontinued and a tab alarm was applied to the wheelchair per the physician's order. 2. The facility's Director of Clinical Services/Nurse Manager reviewed all current facility residents to ensure that any residents with a restraint currently in place had been appropriately assessed prior to the placement of that restraint and a physician's order was in place for that restraint. Any residents identified as not having had a prior assessment for a restraint or a current physician's order in place for a restraint, had that restraint discontinued until which time the assessment was completed and the physician's order was obtained. The Regional Director of Clinical Services re-educated the facility's Director of Clinical Services/Nurse Managers on the facility's Policy and Procedure for Restraints. The facility's Director of Clinical Services/Education Coordinator re-educated all current facility nursing staff on the facility's Policy and Procedure for Restraints. 3. The facility's Director of Clinical Services/ Nurse Manager will conduct QI monitoring of restraints to ensure that an assessment is completed and a physician's order	

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F 221	Continued From page 5 Medical record review of the physician's recapitulation orders dated October 1, 2012, through October 31, 2012, revealed "...11/28/11: side rails up x (times) 2 bilat (bilateral) while in bed to aid in bedside positioning...7/22/11: Velcro self-release belt with alarm to W/C (wheelchair) to alert staff of unsafe transfer..." Medical record review of the Weekly Nursing Progress Note dated October 10, 2012, revealed "...no restraints..." Observation on October 15, 2012, at 2:30 p.m., in the resident's room, revealed the resident seated in a reclining wheelchair, and a self release seat belt in place. Observation on October 17, 2012, at 7:30 a.m., in the resident's room, revealed the resident lying on the bed with one-half side rails positioned in the middle of the bed, and in the raised position. Interview with the Assistant Director of Nursing (ADON) on October 17, 2012, at 7:40 a.m., at the nurse's station, confirmed the side rails had not been assessed as a restraint and if the resident wanted to exit the bed the resident would go to the foot of the bed. Interview with the Director of Nursing (DON) on October 17, 2012, at 8:24 a.m., at the nurse's station, confirmed the the side rails had not been assessed as a restraint and if the resident wanted to exit the bed the resident would go to the foot of the bed. Observation and interview with the Nurse Consultant on October 17, 2012, at 1:05 p.m., in	F 221	is obtained prior to restraining a resident. QI monitoring will be conducted 3 x weekly for 12 weeks using a sample size of 6. 4. The facility's Director of Clinical Services/ Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision. Substantial Compliance 12-1-12	

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F 221	Continued From page 6 the resident's room, revealed the resident was unable to remove the self release seat belt on command and the facility failed to assess the seat belt as a restraint.	F 221	F-246 1. Residents # 23 and #104 suffered no harm. Resident #23 had their call light placed within their reach on 10-15-12. Resident #104 had their call light placed within their reach on 10-17-12. 2. The facility's Director of Clinical Services/Nurse Managers/Social Services reviewed all current facility residents to ensure that their call lights were placed within their reach. Any current facility residents identified as not having had their call lights within their reach immediately had their call light placed within their reach. The facility's Director of Clinical Services/Nurse Manager re-educated all current facility staff on the facility's Policy and Procedure for Call Lights to ensure that they are within the resident's reach. 3. The facility's Director of Clinical Services/Nurse Manager will conduct QI monitoring of call lights to ensure that they are within the resident's reach. QI monitoring will be conducted 5 x weekly for 4 weeks then 3 x weekly for 8 weeks, then 1 x monthly for 9 months using a sample size of 6. 4. The facility's Director of Clinical Services/Nurse Manager will report results of QI monitoring to the	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a call light within reach for two residents (#23,#104) of twenty-seven residents reviewed of forty-three sampled residents. The findings included; Resident #23 was admitted to the facility on May 19, 2006, with diagnoses including Multiple Sclerosis, Paralysis Agitans, Hypertension, Peripheral Vascular Disease, Latent Nystagmus, External Ophthalmoplegia, and Depressive Disorder. Medical record review of the Care Plan dated October 10, 2012, revealed "Self Care Deficit" with approaches and interventions including "... Keep needed items in easy reach, Call bell in reach..."	F 246		

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F 246	Continued From page 7 Observation on October 15, 2012, at 3:50 p.m., revealed the resident lying on the bed with the privacy curtain pulled. Continued observation revealed the call light on the floor at the head of the bed. Observation and interview with the Medical Records Director on October 15, 2012, at 4:00 p.m., confirmed the call light was on the floor and the resident would not be able to alert the staff of needs or an emergency. Resident #104 was admitted to the facility on October 6, 2009, with diagnoses including: Dementia, Seizure disorder, Hypertension, Peripheral Vascular Disease, and Cerebral Vascular Accident. Medical record review of the Care Plan dated July 11, 2012, revealed "Self Care Deficit" with approaches and interventions including "...Keep needed items in easy reach, Call bell in reach..." Observation on October 17, 2012, at 8:30 a.m. and at 8:45 a.m., revealed the resident lying in bed on left side. Continued observation revealed the call light was not within reach of the resident and was located at the foot of the bed. Interview with the Customer Care Liaison, on October 17, 2012, at 8:55 a.m., confirmed the resident could use call light and the call light was not within reach.	F 246	QA/PI Committee monthly x 12 months for continued compliance and/or revision. Substantial Compliance 12-1-12	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social	F 250	F-250 1. Resident # 6 suffered no harm. Resident #6 has an appointment to see an oral surgeon on 11-7-12 and the Director of Social Services has arranged transportation. 2. The facility's Director of Clinical Services/Nurse Manager reviewed all current facility residents to ensure that they had received dental	

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F 250	Continued From page 8 services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to obtain routine dental services, for one resident (#6) of three resident's reviewed of forty three sampled resident's. The findings included: Resident #6 was admitted to the facility on April 23, 2008, with diagnoses including Senile Delusions, Hyperlipidemia, Senile Depression, Dementia Behavior, Depressive Disorder, Esophageal Reflux and Diaphragmatic Hernia. Medical record review of the annual Minimum Data Set (MDS), dated July 13, 2012, revealed the resident was cognitively impaired and required extensive assistance with activities of daily living. Medical record review of the Annual Dental Exam, dated February 3, 2012, revealed "...teeth...upper several broken teeth...lower several broken teeth...Dr. (named physician) Center for Oral and Facial Surgery..." Medical record review of the Care Plan Conference Record, dated January 5, 2012, revealed "...conference call with daughter...resident has bad teeth, dental consult,	F 250	services in the past year and/or any needed follow-up for dental services had been completed. Any current facility residents identified as not having received dental services and/or any needed follow up for dental services had an appointment scheduled to see the dentist, as applicable. The Regional Director of Clinical Services re-educated the facility's Administrator, Director of Clinical Services and facility's Director of Social Services on the facility's Policy and Procedure for Provision of Dental Services. The facility's Director of Clinical Services/Director of Social Services/Education Coordinator re-educated all current facility Department Management staff, as well as all current nursing staff on the facility's Policy and Procedure for the Provision of Dental Services. 3. The facility's Director of Clinical Services/Social Services Director will conduct QI monitoring to ensure that facility residents receive dental services at least yearly and/or any additional follow-up dental services, as applicable. QI monitoring will be conducted 3 x weekly for 4 weeks, then 1 x weekly for 8 weeks, then 1 x monthly for 9 months using a sample size of 6.	

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F 250	Continued From page 9 MD consult...continue with current POC (plan of care)..." Medical record review of the Care Plan, dated April 26, 2012, revealed "...has poor dentation..,is dependent on staff for oral care...arrange follow up appointments with dentist as indicated..." Medical record review of the Social Service Progress Notes, dated January 5, 2102, revealed "...Dr (physicians name) recommended resident go to a dentist office for cleaning and to get teeth looked at because it cannot be done in the facility...however, (resident's family) does not want to pay for transportation...social worker will follow up with dentist..." Telephone interview with the resident's family member on October 17, 2012, at 11:10 a.m., revealed the resident had numerous broken teeth and an appointment with a dental surgeon had been made. Continued interview revealed "...the facility called me and told me they could not arrange the transportation by ambulance for the resident...resident is in a geri-chair and we cannot get the chair in the vehicle and we need an ambulance...the appointment was cancelled and never rescheduled..." Interview with the Social Service Director on October 17, 2012, at 1:00 p.m., in the East Nurses Station, confirmed the facility failed to follow up on the appointment and arrange transportation for the resident.	F 250	4. The facility's Director of Clinical Services/Social Services Director will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision. Substantial Compliance 12-1-12	
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT	F 252	F-252 1. Resident # 1 suffered no harm. Resident #1 had a television, clock, and flowers placed in her room, per request on 11-16-12.	

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F 252	Continued From page 10 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a homelike environment for one resident (#1) of twenty-seven residents reviewed of forty-three sampled residents. The findings included: Resident #1 was admitted to the facility on July 23, 2002, and readmitted July 22, 2011, with diagnoses including Dementia, Anxiety, Left Hemiparesis, and Anemia. Medical record review of the quarterly Minimum Data Set (MDS) dated August 20, 2012, revealed the resident was cognitively intact, totally dependent for all activities of daily living, no restraint in use, and incontinent of bowel and bladder. Observation on October 15, 2012, at 2:30 p.m., in the resident's room, revealed the resident seated in a reclining wheelchair, self release seat belt in place, and teeth in poor condition. Further observation at this time revealed the resident had no pictures, television, knickknacks, or personal items belonging to the resident. Interview with the Social Service Director on October 16, 2012, at 3:33 p.m., in the resident's room, confirmed the facility failed to provide a	F 252	2. The facility's Director of Clinical Services/Director of Social Services reviewed all current residents to ensure that the facility is providing them with a homelike environment. Any current residents identified as not having a homelike environment had revisions made to their rooms per their requests to ensure that their environment is one that is homelike. The Regional Director of Clinical Services re-educated the facility's Director of Clinical Services/Director of Social Services on the facility's Policy and Procedure for Provision of a Homelike Environment. The facility's Director of Clinical Services/Director of Social Services/Education Coordinator re-educated all current facility staff on the facility's Policy and Procedure for Provision of a Homelike Environment. 3. The facility's Director of Clinical Services/Director of Social Services will conduct QI monitoring to ensure a homelike environment for all residents. QI monitoring will be conducted 3 x weekly x 4 weeks, then 1 x weekly for 8 weeks, then 1 x monthly for 9 months using a sample size of 6. 4. The facility's Director of Clinical Services/Director of Social Services will report results of QI monitoring to the QA/PI Committee monthly x	

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F 253 Continued From page 11
SS=D MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by
Based on observation and interview, the facility failed to maintain and repair baseboards for three of sixty three resident's rooms observed and failed to maintain a clean environment for one of sixty three resident's rooms observed.

The findings included:

Observation on October 17, 2012, at 2:35 p.m. with the maintenance director, on the East Wing hall, revealed the base boards in three resident's rooms were torn from wall and cracks were found in the drywall at the base of the wall.

Observation on October 17, 2012, at 2:35 p.m. with the maintenance director, on the East Wing hall, revealed a brown dried debris on the bottom of the wall just outside of a resident's bathroom.

Interview with the maintenance director on October 17, 2012, at 2:35 p.m., in the East Wing hallway, confirmed the baseboards were torn from the wall and in need of repair and confirmed the brown dried debris on the wall in a resident's room.

F 278 483.20(g) - (j) ASSESSMENT
SS=E ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the

F 253

4. 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

F-253

1. The identified residents on the East Wing suffered no harm. The facility's Maintenance Director repaired the torn baseboards for the three identified residents on the East Wing on 10-19-12. The Housekeeping Director removed the brown debris located at the base of the wall for one identified resident on the East Wing and completed a deep cleaning of the identified resident's room on 10-19-12.
2. The facility's Administrator/Maintenance Director/Housekeeping Supervisor reviewed all current residents' rooms to ensure that the baseboards were intact and that the residents' rooms were maintained in a clean fashion. Any current resident's room identified as not having baseboards intact or identified as not being clean was corrected accordingly. The facility's Administrator re-educated the facility's Maintenance Director and Housekeeping Supervisor on the facility's Policy and Procedure for Maintaining a Sanitary, Orderly and Comfortable Interior. The facility's

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F 278 Continued From page 12

resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals

A registered nurse must sign and certify that the assessment is completed

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment, or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to complete the Minimum Data Set (MDS) accurately for three (#1, #122, #6) residents of twenty-nine residents reviewed of forty-three sampled residents

The findings included:
Resident #1 was admitted to the facility on July

F 278

Administrator/Maintenance Director re-educated all current maintenance staff and all current housekeeping staff on the facility's Policy and Procedure for Maintaining a Sanitary, Orderly and Comfortable Interior.

3. The facility's Administrator/Maintenance Director will conduct QI monitoring to ensure that the facility's rooms have baseboards that are intact on the walls and that the rooms are maintained in a clean fashion. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x monthly for 9 months using a sample size of 6.

4. The facility's Administrator/Maintenance Director will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

F-278

1. Residents #1, #122 and #6 suffered no harm. The facility's Minimum Data Set (MDS) Coordinator revised Resident #1's annual MDS dated 2-27-12 to include dental

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23, 2002, and readmitted July 22, 2011, with diagnoses including Dementia, Anxiety, Left Hemiparesis, and Anemia

Medical record review of the annual Minimum Data Set (MDS) dated February 27, 2012 revealed no dental issues addressed

Observation on October 15, 2012, at 2:30 p.m., in the resident's room, revealed the resident seated in a reclining wheelchair, self release seat belt in place, and teeth in poor condition

Medical record review of an Admission Assessment dated July 23, 2002, revealed inflamed gums, upper dentures, and some missing teeth

Medical record review of the Admission Data Collection dated July 22, 2011, revealed "...condition of teeth no dentures, edentulous, gums bleeding, inflamed gums, lesions present "

Interview with the MDS Coordinator responsible for completing the MDS on October 16, 2012, at 3:46 p.m., in the MDS office, confirmed a dental assessment had not been completed

Medical record review of the quarterly MDS for resident #1 dated August 20, 2012, revealed no restraint in use

Observation on October 17, 2012, at 7:30 a.m., in the resident's room, revealed the resident lying on the bed with one-half side rails positioned in the middle of the bed, and in the raised position

Medical record review of a Quarterly Data

issues related to missing teeth, inflamed gums and upper dentures. The facility's MDS Coordinator revised Resident #1's quarterly MDS dated 8-20-12 to include restraints in use. The facility's MDS Coordinator revised Resident #122's quarterly MDS dated 8-27-12 to include impairment of the lower extremities. The facility's MDS Coordinator revised Resident #6's quarterly MDS dated 7-13-12 to include that the resident wears glasses. The facility's MDS Coordinator revised Resident #6's annual MDS dated 4-21-12 to include broken teeth, and inflamed or bleeding gums.

2. The facility's MDS Director reviewed all current facility residents to ensure that their most recent MDS assessment completed in the past 90 days accurately reflects the resident's status. Any residents identified as not having been accurately assessed per their most recent MDS assessment in the past 90 days, had a revision completed to accurately reflect the resident's status. The Regional Director of MDS re-educated the facility's Director of MDS and Director of Clinical Services on the facility's Policy and Procedure for MDS Assessment Completion to ensure that the MDS assessment

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F 278	Continued From page 14	F 278		

Collection dated August 11, 2012, revealed no restraint in use.

Medical record review of the physician's recapitulation orders dated October 1, 2012, through October 31, 2012, revealed " 11/28/11 side rails up x (times) 2 bilat (bilateral) while in bed to aid in bedside positioning 7/22/11 Velcro self-release belt with alarm to W/C (wheelchair) to alert staff of unsafe transfer "

Interview with the MDS Coordinator responsible for completing the MDS on October 17, 2012, at 9:44 a.m., in the MDS office, confirmed a side rail assessment had not been completed and the facility failed to complete a comprehensive assessment.

Resident #122 was admitted to the facility on March 14, 2011, with diagnoses including Osteoarthrosis, Contracture Left Leg, Chronic Obstructive Pulmonary Disease, and Hypertension

Medical record review of the Quarterly Minimum Data Set (MDS) dated March 14, 2012, revealed the resident had impairment of the lower extremity. Medical record review of the Quarterly MDS dated August 27, 2012, revealed the resident had no impairment of the lower extremity.

Observation on October 17, 2012, at 8:30 a.m. revealed the resident seated in a wheelchair, in the dining room. Further observation revealed the bilateral knees were contracted

Interview on October 17, 2012, at 8:20 a.m., with

accurately reflects the status of the resident.

3. The facility's Director of Clinical Services/MDS Coordinator will conduct QI monitoring of MDS Assessment Completion to ensure that the MDS assessment accurately reflects the status of the resident. QI monitoring will be conducted 3 x weekly for 12 weeks then 1 x monthly for 9 months using a sample size of 6.
4. The facility's Director of Clinical Services/ Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

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the MDS Coordinator #1, in the MDS office, confirmed the MDS was not accurate

Resident #6 was admitted to the facility on April 23, 2008, with diagnoses including Senile Delusions, Hyperlipidemia, Senile Depression, Dementia Behavior, Depressive Disorder, Esophageal Reflux and Diaphragmatic Hernia

Medical record review of the quarterly MDS, dated July 13, 2012, revealed " . vision-sees large print, but not regular print in newspapers or books Corrective lenses (contacts, glasses or magnifying glasses) used "No" "

Medical record review of Admission Nursing Assessment, dated September 19, 2009, revealed " ..Visual appliances "Glasses" "

Interview with the MDS Coordinator #1, on October 17, 2012, at 8:40 a.m., in the MDS office, confirmed the MDS was inaccurate related to the resident vision status and the resident did wear glasses.

Medical record review of the annual Minimum Data Set (MDS), dated July 13, 2012, revealed the resident was cognitively impaired and required extensive assistance with activities of daily living.

Medical record review of the annual MDS, dated April 21, 2012, revealed Oral and Dental Status, "Z"- None of the above were present, related to broken teeth, dentures, inflamed or bleeding

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F 278	Continued From page 16 gums, mouth or facial pain. Medical record review of the Annual Dental Exam, dated February 3, 2012, revealed "...teeth-upper-several broken teeth, Lower-Several broken teeth...there appear to be broken teeth in the lower arch...chronic gingivitis..." Observation on October 16, 2012, at 3:55 p.m., in the resident's room, revealed the resident had numerous upper broken teeth and no lower teeth. Interview with the MDS coordinator on October 17, 2012, at 8:40 a.m., in the MDS office, confirmed the MDS assessment on April 21, 2012, was inaccurate related to the Oral and Dental Status and the resident had several broken teeth on the upper plate.	F 278	F-279 1. Residents #46, #84, #102, and #91 suffered no harm. The facility's MDS Coordinator updated Resident #46's care plan to include interventions to address the resident's impaired vision. The facility's MDS Coordinator updated Resident #84's care plan to include interventions to address discharge needs. The facility's MDS Coordinator updated Resident # 102's care plan to include that the AV shunt is located in the resident's right arm, and there should be no blood pressure or needle sticks to the resident's right arm along with emergency care to be performed in the event that bleeding occurs to the resident's right arm. The facility's MDS Coordinator updated Resident #91's care plan to include interventions addressing the resident's impaired vision. 2. The facility's Director of Clinical Services/ MDS Coordinator/Nurse Managers/Nurse Managers reviewed all current facility residents' comprehensive care plans to ensure that they include interventions to address the needs of the resident. Any resident identified as having a need which was not addressed, per the comprehensive plan of care, had	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		

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F 279	Continued From page 17	F 279		

due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on medical record review, observation, and interview, the facility failed to develop a care plan to meet the resident's needs for four residents (#46, #84, #102, #91) of twenty-seven residents reviewed of forty-three sampled residents.

The findings included:

Resident #46 was admitted to the facility on May 25, 2012, with diagnoses including Hypertension, End Stage Renal Disease, Hepatitis C, Diabetes, and Schizophrenia.

Medical record review of the admission Minimum Data Set (MDS) dated June 1, 2012, revealed the resident had impaired vision (sees large print, but not regular print in newspapers or books), and corrective lens were not used.

Medical record review of the Care Plan dated August 27, 2012, revealed no interventions to address the resident's impaired vision.

Observation on October 17, 2012, at 10:30 a.m., revealed the resident seated in a geri-chair in the resident's room. Interview with the resident, at this time, revealed the resident liked to read the newspaper. Continued interview revealed the resident was not able to see the newspaper print.

their care plans revised to include interventions to address their needs. The Regional Director of MDS re-educated the facility's Director of Clinical Services and MDS Coordinator on the facility's Policy and Procedure for Development of a Comprehensive Care Plan to ensure that it includes interventions to address the needs of the resident. The Director of Clinical Services/MDS Coordinator/Education Coordinator re-educated the current facility licensed nursing staff on the facility's Policy and Procedure for Development of a Comprehensive Care Plan to ensure that it includes interventions to address the needs of the resident.

3. The facility's Director of Clinical Services/MDS Coordinator will conduct QI monitoring of the resident's comprehensive care plan to ensure that it includes interventions to address the needs of the resident. QI monitoring will be conducted 3 x weekly for 12 weeks using a sample size of 6.
4. The facility's Director of Clinical Services/MDS Coordinator will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

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F 279	Continued From page 18	F 279		

Interview on October 17, 2012, at 10:10 a.m., with MDS Coordinator #1, in the MDS office, confirmed the Care Plan did not address the resident's impaired vision.

Resident #84 was admitted to the facility on August 14, 2012, with diagnoses including Diabetes, Hypertension, Atrial Fibrillation, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease.

Medical record review of the Social Services notes dated August 21, 2012, revealed the resident planned to return home after receiving physical and occupational therapy at the facility.

Medical record review of the Care Plan dated August 27, 2012, revealed no interventions to address the resident's discharge needs.

Interview on October 16, 2012, at 2:30 p.m., with the Director of Nursing (DON), in the DON's office, confirmed the Care Plan did not address the resident's discharge needs.

Resident #102 was admitted to the facility on December 31, 2011, with diagnoses including Chronic Kidney Disease Stage IV, Congestive Heart Failure, Coronary Artery Disease, Peripheral Neuropathy, and Renal Failure with Dialysis.

Medical record review of the physician's recapitulation orders dated October 1-31, 2012, revealed physician's orders for emergency care if bleeding occurs to right (R) arm, no labs or blood pressure in (R) arm, and monitor shunt for bruit

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and thrill every shift to (R) arm.

Medical record review of the Dialysis Care Plan dated May 18, 2012, revealed "...AV shunt left arm.. no B/P (blood pressure) or sticks in L (left) arm...emergency care if bleeding occurs to L (left) arm..."

Observation on October 17, 2012, at 9:49 a.m., in the resident's room, revealed the dialysis shunt was located in the right arm.

Interview on October 17, 2012, at 9:53 a.m., with Registered Nurse #2 at the West nursing station, confirmed the dialysis shunt was located in the right arm.

Interview on October 17, 2012, at 9:55 a.m., with the Director of Clinical Services in the Care Plan office, confirmed the care plan was incorrect related to the site of the dialysis shunt.

Resident #91 was admitted to the facility on October 2, 2010, with diagnoses including Muscle Weakness, Congestive Heart Failure, Diabetes, and Dementia with Behavior.

Medical record review of the Quarterly Minimum Data Set (MDS) dated February 20, 2012, revealed the resident had adequate vision. Medical record review of the Significant Change in Condition MDS dated August 4, 2012, revealed the resident had impaired vision.

Medical record review of the care plan dated August 13, 2012, revealed no documentation of the resident's impaired vision.

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F 279	Continued From page 20 Interview on October 16, 2012, at 4:45 p.m., with the MDS Coordinator #1, in the MDS office, confirmed the care plan had not been developed for the resident's impaired vision.	F 279	F-313 1. Resident #46 suffered no harm. Resident #46 was seen by the Optometrist on 10-25-12 for an eye exam. 2. The facility's Director of Clinical Services/Social Services Director reviewed all current facility residents to ensure that they had an eye exam in the past year. Any residents identified as not having had an eye exam in the past year were referred to the Optometrist for an eye exam, as applicable. The Regional Director of Clinical Services re-educated the facility's Director of Clinical Services and Social Services Director on the facility's Policy and Procedure for the Provision of Vision Services to ensure that residents have an eye exam yearly. The facility's Director of Clinical Services/Social Services Director/Education Coordinator re-educated licensed nursing staff on the facility's Policy and Procedure for the Provision of Vision Services to ensure that residents have an eye exam yearly. 3. The facility's Director of Clinical Services/Social Services Director will conduct QI monitoring of vision services to ensure that residents have had an eye exam within the past year. QI monitoring will be conducted 3 x weekly for 12	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain vision services for one resident (#46) of three residents reviewed of forty-three sampled residents. The findings included: Resident #46 was admitted to the facility on May 25, 2012, with diagnoses including Hypertension, End Stage Renal Disease, Hepatitis C, Diabetes, and Schizophrenia. Medical record review of the admission Minimum Data Set dated June 1, 2012, revealed the resident had impaired vision (sees large print, but not regular print in newspapers or books), and corrective lens were not used.	F 313		

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F 313	Continued From page 21 Medical record review revealed no documentation the resident had received an eye examination. Observation on October 17, 2012, at 10:30 a.m., revealed the resident seated in a geri-chair in the resident's room. Interview with the resident, at this time revealed the resident liked to read the newspaper. Continued interview revealed the resident was not able to see the newspaper print. Interview on October 17, 2012, at 10:40 a.m., with the Customer Care Liaison, in the social services office, confirmed the resident had not been referred for an eye examination.	F 313		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to properly administer medications in four of fifty-six opportunities resulting in a 7.14% medication error rate The findings included: Resident # 14 was admitted to the facility on November 3, 2009, with diagnoses including Diabetes Mellitus Type II, Hypertension, and Senile Dementia. Medical record review of the monthly physician's	F 332	1. Residents # 14, #16, and #86 suffered no harm. Resident #14's Nurse Practitioner was notified of medication error on 10-15-12 and new orders were given, received, and implemented. Resident #14's Conservator was notified of medication error on 10-15-12. Resident #14's nurse was re-educated/counseled on 10-15-12. Resident #16's Nurse Practitioner was notified of medication error on 10-16-12 and new orders were given, received, and implemented. Resident #16's Conservator was notified of medication error on 10-16-12. Resident #16's contaminated eye medication was discarded and replaced with a new bottle of eye medication. Resident #16's nurse was re-educated/counseled on 10-17-12. Resident #86's Nurse Practitioner	

F- 332

weeks then 1 x monthly for 9 months.

4. The facility's Director of Clinical Services/Social Services Director will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

NOV 0 1 2012

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F 332	Continued From page 22	F 332		

recapitulation orders dated October 1-31, 2012, revealed "...Lantus (insulin) 13 units Sub-Q (subcutaneous) twice daily...Humalog (insulin) FSBS (finger stick blood sugar) with SS (sliding scale) BID (twice daily)..."

Observation on October 15, 2012, at 4:22 p.m., in the resident's room, revealed Registered Nurse (RN) #1 administered Humalog three units in a syringe mixed with Lantus thirteen units in the right arm of resident #14.

Facility policy review of Injectable Insulin Checklist revealed " . mixing of insulins ..Lanutus should not be mixed with other insulins . failure to adhere to the procedure may result in a loss of blood sugar control "

Interview with RN #1 on October 15, 2012, at 4:30 p.m., in the 200 hallway, confirmed the insulins were mixed and given together in the same syringe

Interview with the Director of Nursing on October 15, 2012, at 4:44 p.m., in the conference room, confirmed the insulin was not to be administered together.

Resident # 95 was admitted to the facility on September 3, 2012, with diagnoses including Dementia, Glaucoma, and Hypertension.

Medical record review of the monthly physician's recapitulation orders dated October 1-31, 2012, revealed ". .Trusopt (eye drops for glaucoma) one drop in both eyes twice daily. "

Observation on October 16, 2012, at 8:56 a.m., in

was notified of medication error on 10-16-12 and new orders were given, received, and implemented. Resident #86's Responsible Party was notified of medication error on 10-16-12. Resident # 86's nurse was re-educated/counseled on 10-16-12.

2. The facility's Director of Clinical Services/Nurse Manager reviewed all current residents' medications to ensure that they were being administered properly. Any current resident's medication indentified as not having been administered properly was reported to the Physician for any further intervention, as well as notification made to the Responsible Party, as applicable. Facility nurses identified as not having given medications appropriately were immediately re-educated/counseled. The facility's Director of Clinical Services/Education Coordinator re-educated all current Licensed Nursing Staff on the facility's Policy and Procedure for Medication Administrator to ensure medications are being administered properly.
3. The facility's Director of Clinical Services/Nurse Manager will conduct QI monitoring of Medication Administration to ensure that medications are administered properly. QI

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the resident's room, revealed Licensed Practical Nurse (LPN) #1 administered Trusopt to each eye and the dropper was placed in the residents tear duct.

Facility policy review of Eye Drop Administration dated January 2007, revealed "...draw lower lid away from the eyeball to form a small pocket...drop the solution into the middle of the lower lid Do not touch eye with dropper..."

Interview with LPN #1 on October 16, 2012, at 9:00 a.m., in the 200 hallway, confirmed the dropper was placed in the resident's tear duct. Continued interview at this time confirmed LPN #1 was unable to determine the amount of Trusopt administered to the resident

Observation on October 16, 2012, at 4:23 p.m., revealed Registered Nurse (RN) #3 placed medications for resident #86 in a plastic pouch, in order to crush the medications, including Propranolol HCL (Hydrochloride) 20 mg (milligrams) for blood pressure, placed the crushed medications in applesauce, and administered the medications to the resident in the resident's room.

Further observation at the medication cart outside the resident's room, revealed one-half of the Propranolol HCL 20 mg pill had been left inside the package and was not administered to the resident.

Review of the physician's recapitulation orders dated October 1-31, 2012, revealed a physician's order for Propranolol HCL 20 mg take one tablet

monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks , then 1 x weekly for 4 weeks, then 1 x monthly for 9 months using a sample size of 5 (two nurses are to monitored on 7-3 shift and 3-11 shift and one nurse on 11-7 shift).

4. The facility's Director of Clinical Services/Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

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F 332	Continued From page 24 by mouth twice daily. Interview on October 16, 2012, at 4:40 p.m., with RN #3 at the medication cart in the hallway, confirmed one-half of the Propranolol HCL 20 mg tablet was left in the package and had not been administered to the resident.	F 332	F-333 1. Resident #14 suffered no harm. Resident #14's Nurse Practitioner was notified of medication error on 10-15-12 and new orders were given, received, and implemented. Resident #14's Conservator was notified of medication error on 10-15-12. Resident #14's nurse was re-educated/counseled on 10-15-12. 2. The facility's Director of Clinical Services/Nurse Manager reviewed all current residents to ensure that no residents had a significant medication error in the past 30 days. Any current residents identified as having a significant medication error in the past 30 days had their Physician notified for any further intervention, as well as notification to the Responsible Party, as applicable. Facility nurses identified as having made a significant medication error were immediately re-educated/counseled. Additionally, the facility's Director of Clinical Servicers/Nurse Manager reviewed all diabetic residents to ensure that any with physician's orders for Lantus or Levemir had indicated on their Medication Administration Record (MAR) the following statement, "Do Not Mix Lantus and/or Levemir with Any Other Insulins." Any current diabetic residents with	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to prevent a significant medication error for one resident (#14) of twelve sampled residents The findings included: Resident # 14 was admitted to the facility on November 3, 2009, with diagnoses including Diabetes Mellitus Type II, Hypertension, and Senile Dementia. Medical record review of the monthly physician's recapitulation orders dated October 1, 2012, through October 31, 2012, revealed "...Lantus (insulin) 13 units Sub-Q (subcutaneous) twice daily...Humalog (insulin) FSBS (finger stick blood sugar) with SS (sliding scale) BID (twice daily)..." Observation on October 15, 2012, at 4:22 p.m., in the residents room, revealed Registered Nurse (RN) #1 administered Humalog three units in a	F 333		

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F 333 Continued From page 25

syringe mixed with Lantus thirteen units in the right arm of resident #14.

Facility policy review of Injectable Insulin Checklist revealed "...mixing of insulins . Lanutus should not be mixed with other insulins failure to adhere to the procedure may result in a loss of blood sugar control..."

Interview with RN #1 on October 15, 2012, at 4:30 p.m., in the 200 hallway, confirmed the insulins were mixed and given together in the same syringe.

Interview with the Director of Nursing on October 15, 2012, at 4:44 p.m., in the conference room, confirmed the insulin was not to be administered together.

F 371 SS=F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observation, facility policy review, and interview, the facility failed to timely discard leftovers in the dietary department, facility staff failed to wash the hands appropriately in the

F 333

physician's orders for Lantus and/or Levemir identified as not having this statement indicated on their MAR, had this statement added to their MAR and notification was made to the pharmacy. The facility's Director of Clinical Services/Education Coordinator re-educated all current facility Licensed Nursing Staff on the facility's Policy and Procedure for Medication Administration to ensure prevention of significant medication errors as well as the proper administration of Lantus and Levemir, as they are not to be mixed with any other insulins.

3. The facility's Director of Clinical Services/Nurse Manager will conduct QI monitoring of Medication Administration including Lantus and Levemir administration to ensure prevention of significant medication errors. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months using a sample size of 5 (two nurses are to be monitored on 7-3 shift and 3-11 shift and one nurse on 11-7 shift).
4. The facility's Director of Clinical Services/Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12

F 371

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F 371	Continued From page 26	F 371		

dietary department, failed to ensure the ice machine was maintained in a clean condition, and failed to ensure the appropriate temperature of food was maintained.

The findings included:

Observation on October 15, 2012, from 9:55 a.m., through 10:30 a.m., with the Certified Dietary Manager (CDM) revealed the following: located in the walk-in refrigerator approximately one and one half cups of egg salad, dated to be discarded on October 13, 2012, and available for use; the CDM, opened the dumpster outside the facility, reentered the dietary department, and without washing the hands touched the clean pans on the drying rack; and the ice machine had black debris inside the ice machine directly above the ice supply.

Observation on October 15, 2012, at 11:45, of the tray line in the dining room, revealed the temperature of the crab cakes was 110 degrees F (farhenheit).

Review of the facility's policy Leftover Utilization revealed "...Leftovers are utilized within 48 hours..."

Review of the facility's policy Handwashing revealed "...All employees associated with the handling of food shall wash hands...at the following times...after handling garbage..."

Review of the facility's policy Ice Handling revealed "...Ice must be protected from splash, drip, and hand contamination during storage and service..."

months for continued compliance and/or revision.

Substantial Compliance 12-1-12

F-371

1. No facility residents suffered any harm. The facility's Certified Dietary Manager immediately discarded the egg salad on 10-15-12. The facility's Certified Dietary Manager immediately removed the pan for sanitizing and washed her hands on 10-15-12. The facility's Certified Dietary Manager immediately cleaned the ice machine on 10-15-12. The facility's Certified Dietary Manager immediately removed the crab cakes and replaced them with crab cakes at the appropriate temperature of 160 degrees Fahrenheit.
2. The facility's Certified Dietary Manager/Registered Dietician reviewed the facility's dietary department to ensure that leftover food is discarded timely, that staff washes their hands appropriately, that the ice machine is maintained in a clean condition, and that food is maintained at the appropriate temperature. Any variances identified in the dietary department related to leftovers being discarded timely, staff washing their hands appropriately, the ice machine

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F 371	Continued From page 27 Review of the facility's policy Food Handling Guidelines revealed "...Hold potentially hazardous foods at temperatures above 140 degrees F and below 40 degrees F..." Interviews on October 15, 2012, from 9:55 a.m., through 10:30 a.m., with the CDM, in the dietary department, confirmed the egg salad was not discarded timely, the hands were not washed after touching the dumpster prior to touching the clean pans, the ice machine was not clean, and the temperature of the crab cakes was 110 degrees F.	F 371	being maintained in a clean condition, and/or food being maintained at the appropriate temperature, was immediately addressed by the facility's Certified Dietary Manager/Registered Dietician and dietary staff were immediately re-educated/counseled, accordingly. The Registered Dietician re-educated the facility's Certified Dietary Manager on the facility's Policy and Procedure for Leftover Food Utilization, Hand washing, Equipment Cleaning Requirements (including cleaning schedules), and Food Temperature Requirements at Point of Service (including measures to support holding temperatures) to ensure that food is stored, prepared and served under sanitary conditions. The facility's Certified Dietary Manager/Education Coordinator re-educated all current facility dietary staff on the facility's Policy and Procedure for Leftover Food Utilization, Hand washing, Equipment Cleaning Requirements (including cleaning schedules), and Food Temperature Requirements at Point of Service (including measures to support holding temperatures) to ensure food is stored, prepared and served under sanitary conditions. 3. The facility's Certified Dietary Manager/Registered Dietician will	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office, and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to obtain routine dental services, for two residents (#6, #1) of three resident's reviewed of forty three sampled resident's. The findings included:	F 412		

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F 412	Continued From page 28	F 412		

Resident #6 was admitted to the facility on April 23, 2008, with diagnoses including Senile Delusions, Hyperlipidemia, Senile Depression, Dementia Behavior, Depressive Disorder, Esophageal Reflux and Diaphragmatic Hernia

Medical record review of the Annual Dental Exam, dated February 3, 2012, revealed "...teeth...upper several broken teeth...lower several broken teeth.. Dr. (named physician) Center for Oral and Facial Surgery . "

Medical record review of the Care Plan Conference Record, dated January 5, 2012, revealed "...conference call with daughter resident has bad teeth, dental consult, MD consult...continue with current POC (plan of care)..."

Medical record review of the Care Plan, dated April 26, 2012, revealed ". . has poor dentation...is dependent on staff for oral care...arrange follow up appointments with dentist as indicated..."

Medical record review of the social service progress notes, dated January 5, 2102, revealed "...Dr (physicians name) recommended resident go to a dentist office for cleaning and to get teeth looked at because it cannot be done in the facility...however, (resident's family) does not want to pay for transportation...social worker will follow up with dentist..."

Telephone interview with the resident's family member on October 17, 2012, at 11:10 a.m., revealed the resident had numerous broken teeth

conduct QI monitoring of the dietary department to ensure that leftover food is discarded timely, that staff washes their hands appropriately, that the ice machine is maintained in a clean condition, and that food is maintained at the appropriate temperature. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x monthly for 9 months.

4. The facility's Certified Dietary Manager/Registered Dietician will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

F-412

1. Resident # 6 suffered no harm. Resident #6 has an appointment to see an oral surgeon on 11-7-12 and the Social Services Director has arranged transportation. Resident #1 was seen by the dentist on 10-19-12.
2. The facility's Director of Clinical Services/Nurse Manager/Social Service Director reviewed all current facility residents to ensure that they had received dental services in the past year and/or any

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F 412	Continued From page 29	F 412		

and an appointment with a dental surgeon had been made. Continued interview revealed "...the facility called me and told me they could not arrange transport by ambulance for the resident...resident is in a geri-chair and we cannot get the chair in the vehicle and we need an ambulance...the appointment was cancelled and never rescheduled..."

Interview with the Social Service Director on October 17, 2012, at 1:00 p.m., in the East Nurses Station, confirmed the facility failed to follow up on the appointment and arrange transportation for the resident.

Resident #1 was admitted to the facility on July 23, 2002, and readmitted July 22, 2011, with diagnoses including Dementia, Anxiety, Left hemiparesis, and Anemia.

Medical record review of the annual MDS dated February 27, 2012, revealed no dental problems.

Medical record review of the Care Plan dated March 6, 2012, revealed "...poor dentation, will have adequate oral care provided...arrange follow up appointments with dentist..."

Observation on October 15, 2012, at 2:30 p.m., in the resident's room, revealed the resident seated in a reclining wheelchair, self release seat belt in place, and teeth in poor condition.

Interview with the Social Service Director on October 16, 2012, at 3:33 p.m., in the resident's room, confirmed the resident had not been seen by the dentist since March 2011, no dental consult available in the medical record, and the needed follow-up for dental services had been completed. Any current facility residents identified as not having received dental services and/or any needed follow up for dental services had an appointment scheduled to see the dentist, as applicable. The Regional Director of Clinical Services re-educated the facility's Director of Clinical Services and facility's Director of Social Services on the facility's Policy and Procedure for Provision of Dental Services. The facility's Director of Clinical Services/Director of Social Services/Education Coordinator re-educated all current facility Department Management staff, as well as all current nursing staff on the facility's Policy and Procedure for the Provision of Dental Services.

3. The facility's Director of Clinical Services/Social Services Director will conduct QI monitoring to ensure that facility residents receive dental services at least yearly and/or any additional follow-up dental services, as applicable. QI monitoring will be conducted 3 x weekly for 4 weeks, then 1 x weekly for 8 weeks, then 1 x monthly for 9 months using a sample size of 6.
4. The facility's Director of Clinical Services/Social Services Director

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F 412	Continued From page 30 facility failed to provide routine dental services.	F 412		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision. Substantial Compliance 12-1-12 F-441 1. Residents #14, #114, and #16 suffered no harm. The ice container was immediately emptied, sanitized and an ice scoop with a holder was placed on the cart on 10-15-12. The blood glucose basket and medication cart were cleaned on 10-16-12. Resident #16's Nurse Practitioner was notified of medication error on 10-16-12 and new orders were given, received, and implemented. Resident #16's contaminated eye medication was discarded and replaced with a new bottle of eye medication. Resident #16's nurse was re-educated/ counseled on 10-17-12. The nurse who disposed of the lancet in the trash was re-educated/counseled on 10-15-12. 2. The facility's Director of Clinical Services/Nurse Manager reviewed all current facility residents to ensure that infection control practices were being followed during blood glucose monitoring, medication administration, and lunch tray delivery. Any current	

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This REQUIREMENT is not met as evidenced by:
Based on observation, review of facility policy, and interview, the facility failed to follow infection control practices during blood glucose monitoring for two residents (#14, #114) of twelve residents observed during medication administration, medication administration for one (#16) resident of twelve residents observed during medication administration, and lunch tray delivery on one of four halls.

The findings included:

Observation on October 15, 2012, at 12:05 p.m., on the 100 hall, during the lunch tray delivery, revealed Certified Nursing Assistant (CNA) #2 obtained ice with a cup from a plastic bowl (without wearing gloves), dropped the cup in the ice, delivered a meal tray to a resident. Continued observation revealed CNA #3 obtained ice with the same cup left in the ice from the plastic bowl. dropped the cup in the ice, and delivered the meal tray to a resident.

Interview on October 15, 2012, at 12:10 p.m., on the 100 hall, with Licensed Practical Nurse #4 (LPN), confirmed the CNA's failed to follow infection control practices.

Observation on October 15, 2012, at 4:10 p.m., revealed Registered Nurse (RN) #1 retrieved a basket of blood glucose monitoring supplies from the medication room, entered resident #114's room, placed the basket on the resident's bedside

facility residents identified as not having had infection control practices followed during blood glucose monitoring, medication administration and/or lunch tray delivery were addressed immediately and involved staff was immediately re-educated/counseled. The facility's Director of Clinical Services/Education Coordinator re-educated all current facility nursing staff on the facility's Policy and Procedure for Infection Control as related to blood glucose monitoring, medication administration, and lunch tray delivery, as applicable.

3. The facility's Director of Clinical Services/Nurse Manager will conduct QI monitoring of infection control practices as related to blood glucose monitoring, medication administration, and lunch tray delivery. QI monitoring will be conducted 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x monthly for 9 months.
4. The facility's Director of Clinical Services/Nurse Manager will report results of QI monitoring to the QA/PI Committee monthly x 12 months for continued compliance and/or revision.

Substantial Compliance 12-1-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445205	A. BUILDING _____ B. WING _____	10/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF CHATTANOOGA	8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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table without a protective barrier, performed a blood glucose for the resident, placed the basket in a chair in the room, exited the resident's room, and placed the basket on the medication cart. Further observation at this time revealed RN #1 entered resident #14's room, placed the basket on the resident's bedside table without a protective barrier, performed the blood glucose, exited the resident's room, and placed the basket on the medication cart.

Interview with the Director of Nursing (DON) on October 17, 2012, at 10:30 p.m., in the DON office, revealed a protective barrier was to be placed under the basket and confirmed the facility failed to follow infection control practice during blood glucose monitoring.

Observation on October 15, 2012, at 4:22 p.m., revealed RN #1 performed a finger stick to obtain a blood glucose for resident #14. Continued observation revealed RN #1 placed the lancet used to complete the finger stick, on the wax paper after the blood glucose. Further observation at this time revealed RN #1 picked up the wax paper with the lancet enclosed, and placed the lancet in the glove as the RN removed the glove. Continued observation at this time revealed the RN placed the lancet (sharps) inside the glove in the trash can.

Review of facility policy Biohazard Waste: Needle/Sharps Handling and Disposal System dated January 2007, revealed "...sharps...shall be handled and disposed of in a safe manner...to prevent the transmission of blood borne organisms...sharps shall be placed directly into a rigid puncture-resistant container after use..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445205	A. BUILDING _____ B. WING _____	10/17/2012

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Interview with RN #1 on October 15, 2012, at 4:22 p.m., confirmed the lancet had not been disposed of properly in the sharps container.

Interview with the DON on October 17, 2012, at 10:30 a.m., in the DON office, confirmed the facility failed to dispose of sharps in a safe manner.

Observation on October 16, 2012, at 8:56 a.m., in resident #95's room, revealed Licensed Practical Nurse (LPN) #1 administered Trusopt (eye drops for glaucoma) to each eye and the dropper was placed in the residents tear duct at instillation without cleaning the dropper between administartion of the drops to the eyes.

Review of facility policy Eye Drop Administration dated January 2007, revealed "...Do not touch eye with dropper..."

Interview with the Licensed Practical Nurse #1 on October 16, 2012, at 9:00 a.m., in the 200 hallway, confirmed infection control practice was not followed during instillation of eye drops.